County of Orange California
Disability Salary Continuance
Claim Packet Instructions

Standard Insurance Company, Claims Administrator
PO Box 2800 Portland OR 97208-2800 800.368.2859 Tel 800.378.6053 Fax

Dear Disability Salary Continuance Claimant:

The following Disability Salary Continuance information is for your review and action. We understand that being disabled does not cease your financial obligations and we hope that the Disability Salary Continuance benefits assist you during the time that you are unable to work and are off payroll. If you are unable to return to work at the end of your Disability Salary Continuance period, you may be eligible for Long Term Disability (LTD) benefits through The Standard Insurance Company.

This packet contains forms to apply for your Disability Salary Continuance benefits and the Plan Document that provides specific information about the plan. It is also intended to address common questions about Disability Salary Continuance claims and procedures. We recommend that you save this material for your future reference.

How To Apply for Disability Salary Continuance Benefits

A Disability Salary Continuance application includes three forms that must be completed, 1) the claim form, 2) an Authorization to Obtain Information form and 3) IRS form W-4.

1. Complete the section of the claim form called "To be Completed by Employee".
2. Have your physician complete the section on the back of the claim form called "Attending Physician's Statement".
3. Complete the section of the claim form called "Authorization to Obtain Information".
4. Complete the IRS form W-4.
5. Send all forms to:

   County of Orange/Employee Benefits
   10 Civic Center Plaza, 1st Floor Room 107
   Santa Ana, CA 92701

Important Notice: Incomplete forms will cause a delay in processing your disability claim form.

Once all completed forms are received, Employee Benefits will:

1. Request written verification from your agency that all of your accrued sick time has been exhausted. *(For your information, subsequent payment of vacation or comp time will not affect your Disability Salary Continuance payments. Subsequent payment of Catastrophic Leave will affect your Disability Salary Continuance payments. Please contact the Employee Benefits Office as soon as you are awarded Catastrophic Leave.)*
2. Complete the "To Be Completed by Employer" section of the claim form.
3. Send all completed forms to the Standard Insurance Company.

Once The Standard receives your completed claim form, it will take approximately one week to make a claim decision. If a decision has not been reached within one week, you will be notified with the details. Once your claim has been approved, the Standard Insurance Company will consider the applicable elimination period and issue payments each Wednesday as long as you are eligible for benefits.

Pregnancy Related Disabilities

Soon after your baby is born, you must:

1. Notify the Standard Insurance Company at (800) 368-2859 to report the actual date and type of delivery.
2. Submit your Health Insurance Enrollment Card to the Employee Benefits Office if you wish to add your baby to your health plan. You can request an enrollment card from the Employee Benefits Office by calling (714) 834-6282. You have only 30 days after the date of birth to add the baby to your health plan.
3. Submit your Management Benefits Enrollment form to the Employee Benefits Office if you wish to cover your baby under the County Dental Plan or Dependent Life Insurance. You can request an enrollment form from the Employee Benefits Office by calling (714) 834-6282.

(over)

Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive may reduce the amount of Disability Salary Continuance benefits due you. The Disability Salary Continuance Plan Document and Long Term Disability group insurance certificates list these benefits, which may include, but are not limited to, sick leave, Workers' Compensation, Catastrophic Leave and Retirement.

*To avoid a possible overpayment of your Disability Salary Continuance claim, you must contact the Employee Benefits Office at (714) 834-6282 if you receive other benefits while disabled. Any overpayments of Disability Salary Continuance benefits must be repaid in full.

Extension of Disability

In most cases, the Standard Insurance Company will cease benefit payments on the anticipated return to work date your physician indicates on your claim form. If your disability extends past this date, you must:

1. Notify your immediate supervisor.
2. Have your physician complete a new Attending Physician's Statement. An Attending Physician's Statement (APS) or the other medical questionnaire will be included with the correspondence you receive from The Standard. If you need an additional APS or medical questionnaire, you may request them directly from The Standard at (800) 368-2859.
3. Once completed, send the new Attending Physician's Statement to The Standard.

To avoid a lapse in eligible benefit payments, the above steps should take place as soon as you are aware that additional time off work is required due to your disability.

Federal Income Tax Withholding

The Internal Revenue Service requires that Federal Income Tax be withheld from your Disability Salary Continuance Benefits. Therefore, you must complete an IRS Form W-4 and submit it with your disability claim. If you have questions on how you should complete the form, you should contact your tax advisor.

Medicare Tax Withholding

If you were hired by the County of Orange on or after April 1, 1986, the Medicare Tax will be withheld from your Disability Salary Continuance benefits.

Return to Work

If you return to work prior to the anticipated return to work date your physician indicates on your claim form, immediately notify the Employee Benefits Office at (714) 834-6282. This will prevent overpayments of benefits. Any overpayments of Disability Salary Continuance benefits must be repaid in full.

Need Additional Information

We hope that this information addresses any questions you may have had regarding your Disability Salary Continuance plan. If not:

- You should contact the Employee Benefits Office at (714) 834-6282 with general plan questions.
- You should contact the Standard Insurance Company at (800) 368-2859 for specific details about your Disability Salary Continuance claim or determination.

Standard Insurance Company
Claims Administrator

County of Orange California
Disability Salary Continuance
Employer/Employee's Statement

Submit Completed Form to: County of Orange, Employee Benefits, 1st Floor Rm. 107, 10 Civic Center Plaza, Santa Ana, CA 92701

TO BE COMPLETED BY EMPLOYEE

Full Name:	Social Security Number:	Phone No.: ( )	Birthdate:	Sex: ☐ M ☐ F
Mailing Address:		City:	State:	Zip Code:

1. Is your disability work related? ☐ Yes ☐ No

2. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No
   If no, do you intend to file? ☐ Yes ☐ No

3. Last active day at work:

4. Date you became unable to work at your occupation because of disability:

5. Date you returned or expect to return to work:

6. Is your disability due to:
   ☐ Accident. When and where did it happen?

   ☐ Illness. When did you first notice and what is the nature of your disability?

7. How does your disability prevent you from working?

8. Have you had a previous disability claim with The Standard? ☐ Yes ☐ No

9. Pregnancy: Expected delivery date: _____
   Actual delivery date: _____
   Type of delivery: ☐ Vaginal ☐ C-section

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

By signing this statement, you also agree to pay the County of Orange back any Salary Continuance benefits that were paid to you for any period of time for which you also received income or benefits from other sources.

Signature: _____ Date: _____

Have or will you be applying for:
Disability Retirement ☐ Yes ☐ No
Catastrophic Leave ☐ Yes ☐ No

Note to Employee: Complete top portion of Attending Physician's Statement on the back of this form.

TO BE COMPLETED BY EMPLOYER

Employee's Full Name:	Social Security Number:	Job Title:	1. Date Employed:

2. Is employee insured for Short Term Disability? ☐ Yes ☐ No
   Effective date: _____
   Is employee insured for Long Term Disability? ☐ Yes ☐ No
   Effective date: _____
   Is employee insured for Group Life Insurance through The Standard? ☐ Yes ☐ No

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for:
   Workers' Compensation ☐ Yes ☐ No Other: _____

5. Employee's weekly earnings: $ _____

6. Last active day at work: _____

7. Job status when disability began: ☐ Full-time (____ hours/week)
   Rep Unit: _____ Agency: _____

8. Date employee returned to work: _____

9. Last day through which sick leave benefits were paid: _____

10. Last day through which any compensation was paid by employer: _____ Type: _____

11. Is employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

12. Does the employee pay all or a portion of the premium for: STD coverage? ☐ Yes ☒ No LTD coverage? ☐ Yes ☒ No

Employer:	Plan No.:	Phone No.:
The County of Orange	**639024**	**(714) 834-6282**

Mailing Address:	City:	State:	Zip Code:
10 Civic Center Drive, 1st Floor Room 107	**Santa Ana**	**CA**	**92701**

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

Signature: _____ Date: _____ Prepared By: _____

Standard Insurance Company
Claims Administrator

County of Orange California
Disability Salary Continuance
Attending Physician's Statement

TO BE COMPLETED BY EMPLOYEE

Full Name:	Employer: **The County of Orange**	Plan No: **639024**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

The following information is needed to document your patient's inability to work. The patient is responsible for completing this form without expense to the plan sponsor or The Standard.

1. Diagnosis

A. Diagnosis: | ICDA Classification:

B. Symptoms: | C. Objective Findings: Height: _____ Weight: _____ B/P: _____ /_____

2. Pregnancy *(if applicable)*

A. Expected date of delivery: | B. Actual date of delivery: | C. Type of delivery: ☐ Vaginal ☐ C-section

D. Significant complications, if any:

3. History

A. Date you recommended the patient stop work: | **B. When did symptoms appear or accident happen?**

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No | If yes, when? _____

D. Is this condition related to the patient's employment? ☐ Yes ☐ No | E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

4. Treatment

A. Date of first visit: | B. Date(s) of subsequent visits: | C. Date of most recent visit:

D. Planned course and duration of treatment *(include surgery and medications, if any)*:

5. Level of Functional Impairment

A. Describe the patient's physical, mental and cognitive limitations, if any.

B. In a work day given two breaks and a meal break, your patient can:

Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total Hours								With positional change
Sit	8	7	6	5	4	3	2	1	*(hrs)* _____
Stand	8	7	6	5	4	3	2	1	*(hrs)* _____
Walk	8	7	6	5	4	3	2	1	*(hrs)* _____
Alternately sit/stand	8	7	6	5	4	3	2	1	*(hrs)* _____

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

C. Is this patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

6. Hospitalization *(if applicable)*

A. Date admitted: Date discharged: | B. Reason:

C. Name and location of hospital (city/state):

7. Prognosis

A. Since onset of symptoms, the patient's condition has: ☐ Improved ☐ Not changed ☐ Retrogressed

B. When do you anticipate the patient can return to work? ☐ **Date:** _____ ☐ **Unable to determine, follow up in** _____ **weeks** ☐ **Never**

8. Physician Information *(Please type or print)*

Name of physician completing this form: | Phone Number: ( )

Specialty: | Tax ID#: | Fax Number: ( )

Mailing Address: | City: | State: | Zip Code:

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

Signature: _____ Date: _____

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER APPLICANTS AND CLAIMANTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

The STANDARD INSURANCE

County of Orange California
Disability Salary Continuance
Authorization to Obtain Information

Standard Insurance Company, Claims Administrator
PO Box 2800 Portland OR 97208-2800 800.368.2859 Tel 800.378.6053 Fax

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, etc.)*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

  and:
- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, or eligibility for other benefits *(for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO THE COUNTY OF ORANGE AS PLAN SPONSOR AND STANDARD INSURANCE COMPANY ACTING AS ITS CLAIMS ADMINISTRATOR.

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction. I understand that The County of Orange California and The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The County of Orange California and The Standard. I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The County of Orange California and The Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The County of Orange California and The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The County of Orange California and The Standard may disclose to other parties information it has about me. The County of Orange California and/or The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The County of Orange California and The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations *(if applicable)* on the following page. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name *(please print)* _____ Social Security No. _____

Signature of Claimant/Guardian/Representative _____ Date _____

This Authorization is a two-page document. Please see page 7 for additional terms and information. Both pages are part of the Authorization.

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

Confidential Abuse Information means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. For additional information about the treatment of confidential abuse information, see accompanying Notice of Confidential Abuse Information Practices. With respect to confidential abuse information, I may revoke this authorization in writing, effective ten days after receipt by The Standard, and I understand that doing so may result in a claim being denied or may adversely affect a pending insurance action.